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Attitudes to lesbian, gay, bisexual and transgender parents seeking health care for their children in two early parenting services in Australia

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ATTITUDES TO LESBIAN, GAY, BISEXUAL AND TRANSGENDER PARENTS SEEKING HEALTH CARE FOR THEIR CHILDREN IN TWO EARLY PARENTING SERVICES IN AUSTRALIA

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ABSTRACT

Aim: to examine the attitudes to and knowledge and beliefs about homosexuality, of nurses and allied professionals in two early parenting services in Australia.

Background: Early parenting services employ nurses and allied professionals. Access and inclusion policies are important in community health and early childhood service settings. However, little is known about the perceptions of professionals who work within early parenting services in relation to lesbian, gay, bisexual and transgender families.

Design: This is the final in a series of studies and was undertaken in two early parenting services in two states in Australia using a cross-sectional design with quantitative and qualitative approaches.

Methods: Validated questionnaires were completed by 51 nurses and allied professionals and tested with Chi-squared test of independence (or Fisher's exact test), Mann–Whitney U-test, Kruskal–Wallis one-way analysis of variance, or Spearman's rank correlation. Thematic analysis examined qualitative data collected in a box for free comments.

Results: Of the constructs measured by the questionnaires, no significant relationships were found in knowledge, attitude and gay affirmative practice scores by sociodemographic variables or professional group. However, attitude to lesbians and to gay men scores were significantly negatively affected by conservative political affiliation ($p=0.038$), held religious beliefs ($p=0.011$), and frequency of praying ($p=0.018$). Six overall themes were found: respect, parenting role, implications for the child, management, disclosure, resources and training.

Conclusions: The study provided an in-depth analysis of the attitudes, knowledge and beliefs of professionals in two early parenting services, showing that work is needed to promote acceptance of diversity and the inclusion of LGBT families in planning, developing, evaluating and accessing early parenting services.

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Relevance to clinical practice: Access and inclusion plans for lesbian, gay, bisexual and transgender families are crucial in early parenting services in Australia and should be included in professional development programs.

Keywords: lesbian, gay, transgender, bisexual, parents, family-centred care, sexuality, homosexuality

What does this paper contribute to the wider global community?

- Parenting centres help parents learn to live with their babies
- Lesbian, gay, bisexual and transgender parents can attend such centres
- Staff need to understand diversity about homosexual parents if they are to give optimum care to these families.

INTRODUCTION

In the same way as the general population do, lesbian, gay, bisexual and transgender (LGBT) parents use health and parenting services when they or their child/ren are faced with health and education challenges. However, there is some evidence that they may feel discrimination during these encounters with the danger that LGBT parents may not so readily access services for their children if they feel uncomfortable doing so. After undertaking a systematic review of the literature on this topic (Zappia et al. 2012), we conducted a series of studies of, firstly, LGBT parents' experiences when having a baby, (Chapman et al. 2012a) and when accessing health care for their children (Chapman et al. 2012b). In subsequent interlinked papers, most published in this journal, we examined the attitudes of health professionals towards LGBT persons, in a range of health care settings (Chapman et al. 2012c, Nicol et al. 2013), and those held by nursing and medical students

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(Chapman et al. 2012d). This paper is the final in the series and examines the attitudes of health professionals working in community early parenting services in two states of Australia.

Early parenting services (EPS) in Australia evolved alongside the infant welfare movement during the first part of last century. Infants during this time were a vulnerable group, with their chances of survival inseparable from maternal health during pregnancy, childbirth and lactation and hence mortality and morbidity were high (Bennett 2013). Mothercraft homes were established in most states of Australia and New Zealand and operated alongside universal child health services (Bennett 2013). These mothercraft homes were decommissioned over time to form the early parenting services we know today. Services have changed and evolved with new evidence that guides the role and direction of services to be relevant in today's society. Multidisciplinary approaches are used in most early parenting services around Australia with a combination of various disciplines working with children and families - namely nurses and midwives, social workers, psychologists and early childhood educators (Bennett 2013, Berry et al. 2015).

Early parenting services all use strengths-based, solution-focused practice approaches and use these in various ways. Over the past decade, studies have demonstrated the importance of moving from an expert paradigm to a partnership approach with the child and family (Berry et al. 2015, Fowler et al. 2012, Wells et al. 2014a, 2014b).

BACKGROUND

For a full expose of the literature about LGBT parents accessing health care for their children, we refer readers to the series of which this paper is part. These were published mostly in this journal, and consisted of, firstly, a systematic review of existing literature found that while many LGBT parents could describe positive experiences of seeking health care for their children, some discrimination and prejudice was felt (Zappia et al. 2012). In a qualitative study, mothers were asked

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to describe their experiences seeking health care for the birth of their babies (Chapman et al. 2012a). Themes about how health care was delivered included 'making the decision'; 'the search'; 'perseverance'; and 'problems of isolation', and it was concluded that while it is now legally possible for lesbians to access reproductive technologies in Australia, they can still suffer from homophobic attitudes held by health staff. A series of questionnaires were used to examine attitudes to, and knowledge and beliefs about homosexuality held by health professionals in a tertiary referral children's hospital (Nicol et al. 2013), and two similarly run second-level hospitals with paediatric services (Chapman et al. 2012c). Similar results were found in all three hospitals, with negative attitudes held by those who held strong religious views, and were conservative voters, while those who had a friend or family member who identified as LGBT, had positive responses. These responses are similar to other studies in this area (Cornelius et al. 2015 ,Röndal et al. 2004, Crisp 2006). Another study which included nursing and medical students (Chapman et al. 2012d) found that overall, knowledge about homosexuality was poor, but the students were willing to learn and adapt their practices to make them culturally safe for LGBT parents and children. These findings are supported in a subsequent literature review by others (Lim et al, 2016).

Throughout the studies it was argued that such attitudes potentially influence the way care is delivered. Family-centred care (Shields 2015) was used as a theoretical framework for the studies. Concern exists that negative attitudes towards LGBT parents will mean family-centred care can never be appropriately implemented for these families.

The aim of this current study is to examine the attitudes to and knowledge and beliefs about homosexuality held by early parenting professionals working in community early parenting settings. To this end, we surveyed staff at two community early parenting services in two Australian states. These services combined have a range of specialised, targeted and universal parenting and early childhood services for their state. These services utilise frameworks that rely on collaboration and the formation of partnership with parents in order to meet their parenting goals (Berry et al. 2015,

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Schmied et al. 2010, Keatinge, Fowler, & Briggs, 2007, Wells et al. 2014a, 2014b). If we know where deficiencies in care and misunderstandings about homosexuality lie, we can tailor education interventions for early parenting professionals, which will then improve the care provided to LGBT parents seeking assistance and care for their children.

METHODS

Study design.

Details of the methods for this cross-sectional study can be found in the previous papers (Chapman et al. 2012b, 2012c, 2012d, Nicol 2013) and in the interests of space will not be repeated here. The settings were two community-based early parenting services, run along similar lines, in two Australian capital cities. One was fully government funded, the other a non-government organisation. Their aims, clientele, usage and staffing profiles are similar. The population for this study was the total professional staff complement of each centre, (44.5 full time equivalent at one and 70 full time equivalent at the other).

Ethics approval was given by the relevant human research ethics committee (HREC11/QRCH/9) and this was ratified by the ethics committees of other institutions involved. We have not included the names of the other ethics committees to ensure privacy, but we can supply these if necessary.

Tools

The questionnaire (the same as the one used in the tertiary and second-level hospitals) included questions about demographic characteristics (including sexual orientation), and also asked if respondents had friends or family who were openly LGBT. We used three validated and trialled

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scales, the Knowledge about Homosexuality Scale (Harris 1995), the Attitude Toward Lesbians and Gay Men Scale (Herek 1994), and to test the consistency of staff beliefs, we used the Gay Affirmative Practice Scale (Crisp 2006). All are known to hold high levels of internal consistency and established construct validity (Herek 1994, Harris 1995, Crisp 2006). Three open-ended questions addressed participants' thoughts, feelings and beliefs about LGBT parents who were accessing health care for their children.

Data collection

The questionnaires were sent to all staff via the internal mail system, and a sealed box was placed in a convenient site for return. The questionnaires were all anonymous, and consent was inferred by their return; 45 were distributed in one site, and 85 at the other (total 130).

Data analysis

Questionnaire data were entered into SPSS, Version 22 for analysis. A random 10% of records were compared with the original questionnaires to check the accuracy of data entry. Due to the skewed nature of the scale scores for attitudes and behaviour, we tested associations between variables using the Chi-squared test of independence (or Fisher's exact test) and differences between professional groups using the non-parametric Mann–Whitney U-test, Kruskal–Wallis one-way analysis of variance, or Spearman's rank correlation tests. Correlations between continuous variables were described using Spearman's rank correlation coefficients, and all statistical tests were performed used two-tailed comparisons with a 95% level of confidence.

The main content of responses to the open-ended questions was conceptualised. Creswell's (2009) eight-step systematic process of analysing textual data was used: 1) read transcripts to get a sense of the whole; 2) focus upon the question "what is that about?"; 3) repeat Step 2 with several

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transcripts to cluster similar topics; 4) use the topics as codes, return to transcripts, and match codes to text to determine a preliminary organising scheme; 5) find descriptive wording for topics to determine categories; 6) reduce categories by grouping topics and finalise categories; 7) assemble data for each category for preliminary analysis and 8) recode existing data with categories. Thematic analysis was completed with the help of QSR NVivo 10, a software package for managing data (QSR International Pty Ltd, 2012).

RESULTS:

Questionnaires were returned by 51 respondents, which included 35 (68.63%) nurses and 16 (31.37%) allied professionals (we use this term rather than "allied health professionals because some were early childhood educators). 41 respondents completed one or more of the qualitative sections of the questionnaire. The overall response rate was 39 percent. A comparison of the age of respondents by professional group was determined by the Mann-Whitney U test. The distributions of the age for nurses and allied professionals were similar. Median age for nurses was 50 years, (IQR 12) and for allied professionals was 49.5 years, (IQR, 16) (not statistically significantly different, $U = 260$, $z = -0.406$, $p = 0.684$).

There was a statistically significant difference observed in the number of years in profession by professional group as assessed by the Mann-Whitney U test. Distributions of the number of years in profession for nurses and allied professionals were similar. Median years in profession for nurses, 30.00, (IQR, 13.79) was statistically significantly higher than in allied/others, 10.00, (IQR, 21.44), $U = 127$, $z = -3.021$, $p = 0.003$. The median years in current setting for nurses was 8.59 years, (IQR, 13.83) was higher than allied professionals, 3.46 years, (IQR, 12.19) but not statistically significantly different, $U = 235$, $z = -0.770$, $p = 0.441$. Similarly, there was no statistically significant difference in the number of years in current position of respondents by position type.

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Further sociodemographic characteristics of the sample are summarised in Table 1. Professional group was significantly associated with reports of ever caring for a child from a LGBT family. A Fisher's exact test for association was conducted between professional group and reports of ever caring for a child from a LGBT family as one expected cell frequency was less than five. There was a statistically significant association between professional group and reports of ever caring for a child from a LGBT family, $p = 0.040$. There was a moderately strong association between professional group and ever caring for a child from a LGBT family, $\varphi = 0.308$, $p = 0.029$. Nurses were more likely than others to report having ever cared for a child from a LGBT family (82.9%) and /or having friends who are openly LGBT (54.3%).

Knowledge, attitude and gay affirmative practice beliefs:

The median knowledge, attitude and gay affirmative practice scores are summarised in Table 2 by sociodemographic characteristics and professional group. A questionnaire was employed to measure different, underlying constructs. One construct, 'knowledge', consisted of 20 questions. The scale had a low level of internal consistency, as determined by a Cronbach's alpha of 0.508. Of the 20 knowledge statements, 22.9% of nurses and 37.5% of allied and other health professionals identified approximately 90% (18) or more of the knowledge statements correctly. We found no significant association between knowledge scores and professional group, marital status, highest qualification, race, political voting behaviour, religious beliefs, the frequency of praying, the frequency of attendance at religious service, ever caring for a child with LGBT parents and having a friend who is openly LGBT (Table 2).

Another construct, 'attitude', consisting of 20 questions was analysed (Table 2). The scale had a high level of internal consistency, (Cronbach's alpha 0.844). General attitudes towards lesbians and gay men differed significantly according to political voting behaviour, religious beliefs and frequency of prayer. There was also a near significant difference according to race (p=0.06). The most negative

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attitudes were found among respondents who reported at least a weekly frequency of prayer, and non-Caucasians, closely followed by those with 'other' party voting behaviour and liberal voters. However, we found no significant association between attitudes and professional group, not having a friend that is openly LGBT, ever caring for a LGBT child, frequency of attendance at religious service, marital status or qualifications. An analysis employing the attitude median subscales attitude to lesbians (ATL) and attitude to gay men (ATGM) was performed (Herek 1994). The ATL construct consisting of 10 questions had a high level of internal consistency (Cronbach's alpha 0.769). The ATGM construct, also consisting of 10 questions, had a medium level of internal consistency (Cronbach's alpha 0.688). Both attitude subscales were significantly associated with political voting behaviour, religious beliefs and frequency of prayer, but not with highest qualification, marital status, frequency of religious attendance, ever caring for a LGBT child and professional group. In addition, ATL was significantly associated with race and having a friend who is openly LGBT.

We examined the Gay Affirmative Practice (GAP) (Crisp 2006) construct which consisted of 15 questions. The scale had a high level of internal consistency (Cronbach's alpha 0.924). We found that 40% of nurses and 43.8% of allied and other health professionals scored 50 or more out of the possible 60, suggesting that roughly half of the respondents hold beliefs consistent with GAP (Table 2). A Spearman's rank-order correlation was run to assess the relationship between knowledge and attitude of respondents towards LGBT persons. Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. There was a moderate negative correlation between knowledge and attitudes towards LGBT persons, $r_s(56) = -0.325$, $p = 0.012$. In addition, knowledge was moderately negatively correlated with ATGM, $r_s(57) = -0.305$, $p = 0.019$ but not significantly negatively correlated with ATL persons, $r_s(57) = -0.252$, $p = 0.054$ suggesting that more negative attitudes are consistent with poor knowledge scores.

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Thematic analysis

Six overall themes emerged from the qualitative data: (1) Respect (2) Parenting role (3) Implications for the child (4) Management (5) Disclosure and (6) Resources and training.

Each will be considered separately. These are briefly shown through exemplary quotations, after which the connections to the aims of the study, regarding attitudes, knowledge and beliefs are explored.

Respect

Respondents demonstrated that they did not take the parents' sexual preferences into account when working with the family; rather they focused on the person's role as a parent and they aimed to work in partnership with them to build parenting capacity.

> *Respect, accept and provide your services regardless of the parents' sexual behaviour, as their parenting skills has nothing to do with their sexual preference.*

Parenting Role

The staff felt that the parenting role was the most important topic for discussion with LGBT parents focussing on how they work together as a parenting team rather than focussing the discussion on impacts of their sexuality on parenting. Respondents talked about the need to understand the dynamics of the family function in order to work with the family on parenting issues.

> *Yes, disclosure of LGBT would be seen as important. The family structure and dynamics within the family would be important to understand from a therapeutic point of view. That is, how does this family work/not work together? Are the parents working together well? What changes might help around the parenting style?*

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Implications for the Child

Respondents talked about the fact that LGBT status should not have major implications on the child but felt that parents being honest with their children from the beginning was an important factor to the child having trust in the parent. There was a recognition that minority groups all have issues with which children need to deal with as they grow up.

> *If teenagers find out about LGBT status for first time then there may be some trust issues. Honesty is usually best approach to disclosing to children plus explanation and education. All minority groups have issues for children growing up.*

Management

Respondents generally felt that there needed to be a shift in the health care paperwork that accompanies an admission to an early parenting service as the current paperwork is not flexible enough for parents to enable appropriate gender identification. This could also relate to accurate data collection for collating family demographics and profiles.

> *Changing documentation/language around who the parents are – for example, forms that say 'mother' and "father' don't allow for variations in family diversity.*

Disclosure

Interestingly, this theme had some diametrically opposing views in relation to disclosure of LGBT status. Respondents who felt that they needed to know about a parents LGBT status talked either about it being important information, or about the need to ensure that appropriate medical testing had been done in relation to the pregnancy. Other staff felt that disclosure was not encouraged by the organisation and that staff would prefer to work with the family like they would any other family.

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I worked as a private practitioner in Sydney mid 80 - mid 90s. I always discussed for the females where the sperm came from. Was the baby HIV tested.

In my workplace, disclosure is not specifically encouraged. However, if it is identified (partner frequently attends too) then I continue to work as I would for any heterosexual couple.

Resources and Training

Respondents felt that training and resources were not provided to adequately meet the needs of the staff in relation to working with LGBT parents. It was generally agreed that targeted education was needed to assist in increasing awareness and sensitivity related to the challenges faced by LGBT parents in their parenting role.

Expand the knowledge of resources aimed at LGBT families so they are supported by people who understand their unique challenges.

In summary, in relation to the aims of the study, the thematic analysis revealed that there were no significant negative attitudes, whilst particularly addressing areas of knowledge and beliefs. It indicated that health and allied professionals were aware of the need for treating attending families according to the needs of their children, regardless of the particulars of the parents involved. Beliefs about LGBT parents seeking health care for their children only become an issue when it concerned building parenting capacity. That is, where challenges faced by children could be better addressed by involving the parents. That requires an understanding of the family functional roles and therefore possibly the way in which LGBT partners fulfil such roles. It also requires an understanding by the children of how the functional roles in their family differ from stereotypical functional roles.

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DISCUSSION

Parenting by LGBT persons is becoming increasingly common and more widely accepted (Ahmann 1999, Perrin et al. 2004, Tellingator & Patterson 2008). However, the exact number of these family groups is largely unknown because many LGBT parents are reluctant to disclose their sexual identity (Ahmann 1999, Neville & Henrickson 2008).

Therefore, social invisibility "perpetuates stigma and shame and undermines a sense of the full meaning of life, morale and well-being" for LGBT people (Webber 2008 p609). Hence research has shown that disclosing one's sexual orientation can lead to an increased use of health services and better satisfaction with care (Barbara et al. 2001, Bergeron & Senn 2003, Garcia 2003, McNair et al. 2008, McNair et al. 2015).

Research overall from this series of studies has found that LGBT parents feel some discrimination and homophobic attitudes held by health care practitioners. Consistent with others (Cornelius et al. 2015, Röndal et al. 2004, Crisp 2006), these negative attitudes were associated with those who held strong religious views and were conservative voters. Positive responses were found in those who had a friend or family member who identified as LGBT. There was generally a poor knowledge base but students were willing to learn which assisted to make LGBT people feel culturally safe. The negative attitudes expressed from these studies indicated that often it becomes more difficult to implement family-centred care for LGBT families.

Our findings are limited to two organisations' experience of nurses' and allied professionals' attitudes, knowledge and beliefs about homosexuality, but are similar to recent studies which have found that more negative attitudes are consistent with poor knowledge scores (Chapman et al. 2012a, 2012b, 2012c, 2012d, Nicol et al. 2013), and in line with other research, (Cornelius et al. 2015, Lim et al 2016,Röndal et al. 2004, Crisp 2006), the most negative attitudes were found among respondents who reported at least a weekly frequency of prayer, and non-Caucasians, closely followed by those with 'other' party voting behaviour and liberal voters.

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Thematic analysis did not demonstrate overall that there were negative attitudes, in fact, the staff wanted to work with the families regardless of LGBT status. This is consistent with a family partnership approach and the opportunity to engage parents as partners in care (Berry et al. 2015, Fowler et al. 2012, Schmied et al. 2010, Wells et al. 2014). Staff using the family partnership model demonstrated respect regardless of LGBT background.

There were opposing views, however, with the approach to respect and understanding of the family dynamics and the question of whether to be open through discussion of parents' LGBT status or to treat them no differently to a heterosexual couple. Some of the staff's responses indicated a tentativeness and/or lack of confidence in working with people who are different from themselves.

Limitations

Unlike the other studies in this series, we used a convenience sample, and had a small sample size, due to the small staffing complements in each of the early parenting services. This was consitient with this descriptive type of study but meant we could not adjuct for multiple conparisons. From this small sample we recruited just over a third of the total population, so the study cannot be generalised to other, similar services. Hence, we may have found some associations by chance. The qualitative arm of the study produced data from just the two groups, who were all employees of the organisations, and so this may have coloured the responses.

Recommendations for practice

Changing the culture in an organisation is necessary at all levels of a service. It is important to assess or audit current practices and plan to address change through review of policy and through education and supervision to create a willingness to learn to ensure the cultural safety of clients.

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Incorporation of LGBT issues and training into access and inclusion frameworks and plans is necessary in order to challenge professionals' values and attitudes and understand the needs of same sex parents and their families.

This study has significant implications for interdisciplinary practice, in particular for education and application for working within this particular practice setting. Nurses and allied professionals need to form complex helping relationships with all parents ensuring that they are respectful, non- discriminatory and non-judgemental in order to work in a family-centred way to ensure the best outcomes for children. Education in relation to gender and gender bias is significantly lacking in relation to the needs of LGBT families and in particular, in allowing staff to identfiy their own biases and parenting frameworks to enable the contextualisation of differences between these in order to work in a more family-centred way.

Further research

A before-and-after study of the effects of training would demonstrate if attitudes and knowledge can be changed in early parenting services in Australia. Studies of cross-cultural perspectives of same-sex parenting would provide valuable data from which interventions and training especially for early parenting services in areas serving multi-ethnic communities could be developed.

Given a family centred care approach it is reasonable to assume the involvement of grandparents, in addition to parents. Similarly, there are numerous situations where children are raised by grandparents, and it is possible that some of those identify as LGBT. As well, further research could explore attitudes toward LGBT grandparents.

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CONCLUSION

This study examined the attitudes to and knowledge and beliefs about homosexuality held by early parenting professionals working in community early parenting settings. The results were encouraging where professionals had been exposed to same-sex couples either personally or during their work. Overall there was some tentativeness when confronted with issues that challenge personal values. Views can be formed on approaches without further knowledge being available on access and inclusion strategies for working with same-sex parents and families. This highlights the need for further research into the effectiveness of increased education in this area of work.

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Table 1. Sample sociodemographic characteristics by professional group

Characteristics	Nurses (n = 35) n (68.63%)	Allied Professionals (n = 16) n (31.37%)	Total Sample (n = 51) n (100%)
Gender			
Female	35 (100.0)	14 (87.5)	49 (96.08)
Male	0 (0)	2 (12.5)	2 (3.92)
Highest qualification			
≤Undergraduate degree	17 (48.6)	9 (56.3)	26 (51.0)
Postgraduate degree	18 (51.4)	7 (43.8)	25 (49.0)
**Work hours			
Full time	11 (32.4)	6 (40)	17 (34.7)
Part time or casual	23 (67.6)	9 (60)	32 (65.3)
Marital status			
Married	28 (80.0)	12 (75.0)	40 (78.4)
Not married	7 (20.0)	4 (25.0)	11 (21.6)
Sexual orientation			
Heterosexual	35 (100.0)	16 (100.0)	51 (100.0)
Other	0 (0)	0 (0)	0 (0)
*Race			
Caucasian	32 (94.1)	14 (87.5)	46 (92.0)
Other	2 (9.9)	2 (12.5)	4 (8.0)
*Religion			
Reported religion	18 (52.9)	10 (62.5)	28 (56.0)
No reported religion	16 (47.1)	6 (37.5)	22 (44.0)
*Religious service attendance			
Weekly or more	6 (17.6)	4 (25.0)	10 (20.0)
Less than weekly	14 (41.2)	6 (37.5)	20 (40.0)
None	14 (41.2)	6 (37.5)	20 (40.0)
Political voting behaviour			
Liberal			
Labor	9 (25.7)	4 (25.0)	13 (25.5)
Greens	14 (40.0)	5 (31.3)	19 (37.3)
None	4 (11.4)	6 (37.5)	10 (19.6)
Other	5 (14.3)	0 (0)	5 (9.8)
	3 (8.6)	1 (6.3)	4 (7.8)
*Cared for child LGBT family	(significant)		
Yes	29 (82.9)	8 (53.3)	37 (74.0)
Unsure or no	6 (17.1)	7 (46.7)	13 (26.0)
*Friends who are openly LGBT			
Yes	19 (54.3)	4 (26.7)	23 (46.0)
Unsure or No	16 (45.7)	11 (73.3)	27 (54.0)

*One person did not respond

** Two people worked 2 jobs and were excluded

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Table 2. Attitude median subscale score comparisons† by selected sociodemographic variables and professional group

Scale	Attitudes to lesbians median (IQR)	*p*	Attitudes to gay men median (IQR)	*p*
Highest qualification				
≤Undergraduate degree	13.0 (4.00)	0.655	16.0 (4.00)	0.945
Postgraduate degree+	14.0 (4.00)		16.0 (4.00)	
Marital status				
Married	14.0 (4.00)	0.210	16.0 (4.00)	0.528
Not married	12.0 (8.00)		15.0 (3.00)	
Race				
Caucasian	13.0 (3.00)	0.015	16.0 (3.50)	0.339
Other	18.0 (10.25)		17.5 (13.00)	
†Political voting behaviour				
None	12.0 (8.50)	0.031	17.0 (8.50)	
Liberal	15.5 (5.75)		18.5 (6.25)	0.038
Labor	12.5 (2.25)		15.0 (1.50)	
Greens	12.0 (2.25)		15.0 (1.75)	
Other	17.0 (10.00)		19.0 (16.00)	
Religious beliefs				
Yes	14.0 (6.50)	0.047	18.0 (4.50)	0.011
No	12.5 (2.00)		15.0 (4.25)	
†Attend religious service				
Weekly+	15.0 (6.00)		18.0 (11.00)	
<Weekly/Other	13.0 (5.00)	0.074	16.0 (4.00)	0.101
None	12.5 (2.75)		15.0 (3.00)	
†Frequency pray				
Weekly+	19.0 (10.50)		18.0 (9.50)	
<Weekly/Other	14.0 (3.50)	0.002	16.0 (3.50)	0.018
None	12.0 (2.00)		15.0 (3.00)	
Ever cared for LGBT child				
Yes	13.0 (3.00)	0.382	16.0 (3.00)	0.476
Unsure or no	14.5 (4.00)		16.0 (5.75)	
Friends openly LGBT				
Yes	14.0 (4.50)	0.051	16.0 (4.00)	0.267
No	12.0 (3.00)		15.0 (3.00)	
Professional group				
Nursing	14.0 (4.00)	0.673	16.0 (4.00)	0.765
Medical	13.3 (4.75)		16.5 (3.75)	
Allied or other				

IQR = interquartile range.

†$p < 0.05$

*Mann–Whitney U-test.

Higher attitude subscale scores indicate more negative attitudes (possible range 10–40).

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Table 3. Knowledge, attitude and gay affirmative practice median scale score comparisons* by sociodemographic variables and professional group

Scale	Knowledge median (IQR)	*p*	Attitudes median (IQR)	*p*	Gay affirmative practice median (IQR)	*p*
Highest qualification						
≤Undergraduate degree	16.0 (3.00)	0.184	30.0 (4.00)		49.0 (5.00)	
Postgraduate degree+	16.5 (3.00)		29.5 (7.75)	1.000	46.50 (5.75)	0.163
Marital status						
Married	16.0 (3.00)		30.0 (6.25)		47.0 (6.00)	
Not married	17.0 (4.50)	0.882	29.0 (5.00)	0.157	48.0 (5.50)	0.890
Race						
Caucasian	16.0 (3.00)		30.0 (5.50)		48.0 (6.00)	
Other	15.5 (7.00)	0.384	35.5 (23.25)	0.060	47.5 (4.00)	0.718
†Political voting behaviour						
None						
Liberal	13.0 (4.50)		29.0 (14.50)		48.0 (6.00)	
Labor	16.0 (3.75)	0.139	33.5 (10.50)	0.006	50.0 (6.25)	0.264
Greens	16.5 (2.25)		29.0 (3.50)		46.0 (5.00)	
Other	17.0 (2.25)		28.5 (4.50)		47.5 (5.50)	
	16.0 (6.50)		34.0 (25.00)		48.0 (4.50)	
Religious beliefs						
Yes	16.0 (3.50)		31.0 (7.75)	0.012	47.0 (5.75)	
No/other	16.0 (3.25)	0.607	29.0 (4.25)		48.0 (6.25)	0.777
†Attend religious service						
Weekly+	17.0 (2.00)		31.0 (19.00)		49.0 (5.00)	
<Weekly/Other	16.0 (3.00)	0.331	30.0 (6.00)	0.166	47.0 (6.00)	0.309
None	16.0 (3.50)		29.0 (5.75)		47.5 (5.75)	
†Frequency pray						
Weekly+	16.0 (3.50)		37.0 (19.50)		48.0 (4.50)	
<Weekly/Other	16.0 (4.00)	0.887	30.0 (6.00)	0.004	47.0 (5.00)	0.686
None	16.0 (2.00)		29.0 (4.50)		48.0 (6.50)	
Ever cared for LGBT child						
Yes						
Unsure or no	16.0 (3.50)		29.0 (6.00)		48.0 (5.00)	
	16.0 (2.00)	0.429	30.5 (6.25)	0.284	46.5 (8.00)	0.668
Friends openly LGBT						
Yes	16.0 (3.50)		30.0 (5.00)		49.0 (6.75)	
No	17.0 (3.00)	0.364	29.0 (5.00)	0.127	48.0 (4.50)	0.691
Professional group						
Nursing	16.0 (2.00)	0.452	30.0 (6.00)		48.0 (5.00)	
Allied/Other	16.0 (2.75)		30.0 (6.25)	0.895	47.0 (7.75)	0.560

Higher knowledge scores indicate greater knowledge (possible range 0–20). Higher attitude scores indicate more negative attitudes (possible range 20–80).

Higher gay affirmative practices indicate greater consistency with gay affirmative practice (possible range 15–60).

*Mann–Whitney U-test.

†Kruskal–Wallis one-way ANOVA.

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